CHAMPVA POLICY MANUAL

CHAPTER: 3
SECTION: 5.7
TITLE: SKILLED NURSING REIMBURSEMENT (HOME HEALTH)

AUTHORITY: 38 USC 1713; 38 CFR 17.270(a) and 17.272(a)

RELATED AUTHORITY: 32 CFR 199.2 and 199.4(c)

TRICARE POLICY MANUAL: Chapter 13, Section 3.10

I. EFFECTIVE DATE

September 27, 1995

II. PROCEDURE CODE(S)

99341-99350

III. DEFINITIONS

A skilled nursing service is a service that can only be furnished by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.), and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired results. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by a layman adult with minimum instructions or supervision. (For example, the pre-filling of insulin syringes can be safely done by a nonmedical person without direct nursing supervision. Therefore, teaching how to pre-fill the syringe would be skilled, but pre-filling the syringes on an ongoing basis would not be skilled.) A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse.

IV. POLICY

A. The skilled nursing service must be medically necessary and appropriate to the diagnosis and treatment of the beneficiary's illness or injury within the context of the beneficiary's unique medical condition. To be considered medically necessary and appropriate for the diagnosis or treatment of the beneficiary's illness or injury, the services must be consistent with the nature and severity of the illness or injury, his or her particular medical needs, and accepted standards of medical and nursing practice. A beneficiary's overall medical condition is a valid factor in deciding whether services

are needed. A beneficiary's diagnosis should never be the sole factor in deciding that a service the beneficiary needs is either skilled or not skilled.

B. Skilled nursing services may be cost shared provided ALL of the following conditions are met:

1. The services are ordered by and included in the treatment plan established by the physician.

2. The services are required due to documented homebound status. (Lack of transportation services does not indicate homebound status.)

3. The services must require the skills of an R.N. or the services of an L.P.N. or L.V.N., under the supervision of a registered nurse or a physician.

4. The services are medically necessary and appropriate to the treatment of an illness or injury.

C. All home health skilled nursing visits must be medically reviewed. If medical documentation does not support a skilled level of care, the claim will be denied.

V. REIMBURSEMENT

A. Claims for skilled nursing services (home health) are paid using the CHAMPVA Maximum Allowable Charge (CMAC) payment methodology (see Chapter 3, Section 5.1, *Outpatient and Inpatient Professional Provider Reimbursement).*

B. An in-home intermittent skilled nursing visit is an all-inclusive unit of service and is reimbursed on a per visit basis. Additional reimbursement is allowed for necessary medical and surgical supplies. These charges must be itemized for proper reimbursement.

C. The medical necessity and appropriateness of skilled nursing service charges, as supported in the daily comprehensive nursing progress notes on all cases under basic home healthcare, are subject to medical review. Where time records of home health visits are unavailable or found to be inaccurate, the reimbursement rate is based on the intermittent visit rather than actual hours of services rendered.

D. Services in excess of 30 days are subject to medical review on a case-by-case basis. Documentation justifying the medical necessity and appropriateness of such additional care is required.

E. If the provider bills at a higher level visit than what is indicated on the daily notes, the claim should be down coded according to the above guidelines.

F. Medical review is required for in-home skilled nursing services longer than four hours duration. The following documentation may be requested to support authorization of these services: current medical status, treatment plan, medical equipment required, estimated period of in-home services, charges, and statement from Social Services regarding non-availability of placement in a skilled facility. Authorization is based on the complexity of care, the overall safety and well being of the patient, and cost containment. Services are reimbursed on an hourly basis, with medical review determining the number of hours per day.

VI. POLICY CONSIDERATIONS

A. The determination of whether the skilled nursing services are medically necessary and appropriate should be made by the physician. The services must, therefore, follow the treatment plan established by the physician. Comprehensive nursing progress notes must document the skilled nursing services provided, the patient's condition, and the patient's response to treatment.

B. Intermittent skilled nursing services means any number of visits per week, up to and including 21 hours per week, for three hours or less per day.

C. Part-time skilled nursing services means any number of visits per week, up to and including 28 hours per week, for four hours per day.

D. Any case requiring or requesting more than four hours per day of skilled nursing services shall be referred for medical review.

E. The amount determined to be the allowable charge for the skilled nursing services is not appealable; however, providers and beneficiaries may request review of claim reimbursement procedures.

F. Home mental health nursing services are allowed when the beneficiary's psychiatric illness is manifested in part by refusal to leave home or is of such nature that it would not be considered safe for the beneficiary to leave home unattended, even if no physical limitations are present. Mental health nursing services are subject to the criteria as outlined in paragraph A. of this section. Such services are subject to the same reimbursement provisions and applicable cost sharing amounts as described in the Reimbursement Section of this policy.

VII. LIMITATIONS

A. Skilled nursing services are limited to those services that are otherwise covered and will be payable only for that time actually required to perform medically necessary skilled nursing services, unless it is shift nursing under case management.

B. Only one new patient home visit per episode of care is payable and that is when the patient is first entered into basic home health care or case management home healthcare.

END OF POLICY